CA MDS NUGGETS

California Department of Public Health VOLUME 4 ISSUE 3 April 2015

Chapter 2 coding Instructions

MDS 3.0

Revision to pages in Chapter 2 and Chapter 3, Section A of the MDS 3.0 RAI manual

An errata document issued by the Centers for Medicare & Medicaid Services (CMS) on February 5, 2015 clarifies the coding instructions on Section A of the RAI user manual released in October 2014. A1600 Entry Date, A1700 Type of Entry, A1800 Entered From, and A1900 Admission Date (date episode of care in this facility began) are additional items identified in this new grouping. The guidance for definition of an admission in the RAI manual remains the same. However, bullet two on page 2-7 under assessment types and definitions is omitted. Coding tips and instructions provided for item A1900, "Admission Date" are located on page A-26 to A-27 of the current RAI manual. Errata information was included in the agenda of the CMS Open Door Forum for Skilled Nursing Facilities (SNF) held on February 12, 2015.

Both nursing homes and swing bed facilities must apply the instructions on page A-26 of the RAI user manual 3.0, October 2014-R, under coding tips and special populations. Coding item A1700 determines whether resident is an admission/entry or a re-entry. (reference is on page A-22)

Coding Instructions

Code 1, admission: when **one** of the following occurs:

1. Resident has never been admitted to this facility before; OR
2. Resident has been in this facility previously and was discharged, return not anticipated; OR
3. Resident has been in this facility previously and was discharged, return anticipated, and did not return within 30 days of discharge.

Code 2, reentry: when **all three** of the following occurred prior to this entry, the resident was:

1. Admitted to this facility, AND
2. Discharged return anticipated, AND
3. Returned to facility within 30 days of discharge.

Special Point of Interest

California Department of PublicHealth

DEFINITION OF ENTRY DATE
The initial date of admission to the facility, or the date the resident most recently returned to your facility after being discharged.

Reentry refers to the situation when **all three** of the following occurred prior to this entry: the resident was previously in this facility and was discharged, return anticipated, and returned within 30 days of discharge. Upon the resident's return, the facility is required to complete an entry tracking record. In determining if the resident returned to the facility within 30 days, the **day of discharge** from the facility is **not counted** in the 30 days. For example, a resident is discharged, with "return-anticipated" on December 1, the resident would need to return to the facility by December 31 to meet the **"within 30 days"** requirement. Start the count from December 2.

Coding Tips and Special Populations (MDS 3.0 Errata Documents 2/2015)

(Chapter 3, section A, page A-26)

A1600 (Entry Date) should be coded with the date the person first entered the facility.

A1700 (Type of Entry) should be coded as 1 for admission, or coded as 2 for reentry.

A1800 (Entered from) the place where the resident was admitted from reflects where the resident was prior to this reentry.

A1900 (Admission Date) should match the date in A1600 (Entry Date) on the Entry Tracking Record and subsequent assessment. It would continue to show the original admission date (the date that began his or her first stay in the episode).

A1600 would change depending on the date of reentry (when resident leaves the facility with discharge return-anticipated, and returned within 30 days).

Most Recent Admission/Entry or Reentry into this Facility

A1600. Entry Date

Month – Day – Year

A1700. Type of Entry

Enter Code

1. Admission
2. Reentry

A1800. Entered From

Enter Code

01. Community (private home/apt., board/care, assisted living, group home)
02. Another nursing home or swing bed
03. Acute hospital
04. Psychiatric hospital
05. Inpatient rehabilitation facility
06. ID/DD facility
07. Hospice
09. Long Term Care Hospital (LTCH)
99. Other

A1900. Admission Date (Date this episode of care in this facility began)

Month – Day – Year

A2000. Discharge Date

Complete only if A0310F = 10, 11, or 12

Month – Day – Year

Issue (MDS 3.0 User Manual- v1.12R) Errata V1

1– Ch. 2, pg. 2-7, under 2.5 Assessment Types and definition, please refer to page 1 of this newsletter.

2– Ch. 2, pg. 2-13, under 2.5 Assessment Types and definition, the definition of ***re-entry*** has changed.

3– Ch. 2, pg. 2-14, page length changed.

4– Ch. 2, pg. 2-19, the situations that require completion of admission assessment no longer include " the resident had been in this facility previously and was discharged prior to completion of the OBRA Admission assessment."

5– Ch. 2, pg. 2-19, under Assessment Management Requirements and Tips for Admission Assessments, there is a formatting error in the bulleted list. The third sentence in the seventh bullet should be a separate bullet.

6– Ch. 2, pg. 2-33, under Example (Reentry), the example does not state the date of discharge.

7– Ch. 2, pg. 2-38, the Entry, Discharge, and Reentry Algorithms figure requires clarification.

8- Ch. 2, pg. 2-57, 2-58, and 2-59, the "-06" option in coding instructions for A0310B should have been deleted since the Medicare PPS Readmission/Return assessment no longer exists.

9– Ch. 2, pg. 2-80, the column header PPS 5-day or readmission/return is incorrect since the Medicare PPS Readmission assessment no longer exists.

10– Ch. 3, Sec. A, pg. A-21, Most recent Admission/Entry or Reentry into this Facility header requires clarification.

11– Ch. 3, Section A, page A-22, under Item Rationale, there is a formatting error.

12– Ch. 3, Sec. A, pg. A-22, the language in the coding instructions does not match the language in the item set.

13– Ch. 3, Sec. A, pg. A-22, Coding Tips and Special Populations contains information that pertains to more than just item A1700.

14– Ch. 3, Sec. A, pg. A-25, the header requires punctuation.

15– Ch. 3, Sec. A, pg. A-25, A1900, the coding of the grouped items A1600-A1800 and A1900 requires clarification.

16– Ch. 3, Sec. A, pg. A-26, the coding of the grouped items A1600– A1800 and A1900 requires clarification.

17– Ch. 3, Sec. A, pg. –27, under coding instructions, there is a formatting error.

18– Ch. #, Sec. A, file length change and text shifts required page number changes from A-23 to the end of the document.

Resolution - Effective February 5, 2015

1– Ch. 2, pg. 2-7, under 2.5 Assessment Types and definitions, the second bullet has been deleted.

2– Ch. 2, pg. 2-13 to 2-14, the definition of re-entry has been amended: please refer to the RAI Errata October 2014-R and on page 2 of this newsletter.

3- The replacement page is provided on the Errata document, October 2014-R.

4– Ch. 2, at the top of pg. 2-19, the second bullet has been deleted. {Note that the header 01, **Admission Assessment (A0310A=01**) and introductory sentence are on page 2-18 which did not change}.

5- The nursing home may combine the Admission assessment with the Discharge assessment when applicable, is now in another bullet.

6– Ch. 2, pg. 2-33 under Example (Re-entry), the date of discharge has been added to the example to clarify that the resident returned to the facility within 30 days of discharge.

7– Ch. 2, pg. 2-38, the Entry, Discharge, and re-entry Algorithms figure has been updated, (old and new).

8– Ch. 2, pg. 2-57, 2-58, and 2-59, the "= 06" option has been deleted for A0310B.

9 – Ch. 2, pg. 2–80, the column header PPS 5-day or readmission/return has been changed to PPS 5-day. Expected orders of the MDS Records is on page 2-80.

10– In Ch. 3, Section A, pg. A-21, the text "A1600-A1800" has been added to identify the items included in the new grouping. **A1600 - A1800: Most Recent Admission/Enter or Reentry into this Facility**

11– Ch. 3. Sec. A, pg. A-22, under item rationale, a space has been added between "the" and "facility."

12– Ch. 3, Sec. A. pg. A-22, under Coding Instructions, the word "entry" has been deleted.

13– The two bullets from Ch. 3, Sec. A, pg. A-22 have been moved to page A-26, after item A1900.

14– Ch. 3, Sec. A, pg. A-24, the colon has been added after A1900 in the header.

15– Ch. 3, Sec. A, pg. A-25, under A1900, four examples have been added to illustrate coding for items A1600, A1700, A1800, and A1900.

16– Ch. 3, Sec. A, pg. A-26, under A1900, Coding tips and Special Populations, the first two bullets have been amended and information has been added to clarify coding.

17– Ch. 3, Sec. A, pg. A-28, under Coding Instructions, a bullet has been added before the text.

18– Replacement pages are provided on the October 2014-(R) release, page A-23.

New about Pneumococcal Vaccine:

The Centers for Disease Control and Prevention (CDC) along with the recommendation of the Advisory Committee on Immunization Practices (ACIP) has issued a new requirement for the pneumococcal vaccine in adults over age 65. They recommend providers now use **two** pneumococcal vaccines for adults ages ≥ 65. These vaccinations are 13-Valent Pneumococcal Conjugate Vaccine (PCV13) and 23-Valent Pneumococcal Polysaccharide Vaccine (PPSV23).

CMS is updating the Medicare coverage requirements to align with the updated ACIP recommendation. Effective for dates of service on or after September 19, 2014, (and upon implementation of CR9051), Medicare will cover:

- An initial pneumococcal vaccine to all Medicare beneficiaries who have never received the vaccine under Medicare Part B; and
- A different second pneumococcal vaccine one year after the first was administered, (that is, 11 full months have passed following the month in which the last pneumococcal vaccine was administered).

The Medicare coverage requirements were implemented on February 2, 2015 and posted in the Medicare Learning Network (MLN) Matters document: MM9051.

In reference to the new requirements and how to code MDS on item O0300: Pneumococcal Vaccine, CMS advises providers to continue to code item O0300 as instructed in the current RAI User's Manual.

Questions and Answers

Q. If a resident chooses to void in their briefs but has bladder control, can this be coded as "continent" on MDS item H0300: Urinary Continence?

A. The definition of continence is any void that occurs voluntarily, or as the result of prompted toileting, assisted toileting, or scheduled toileting. To be able to code a resident "continent" on MDS, the resident must be continent of urine, without any episodes of incontinency during the 7-day look back period. In this situation, the assessor needs to determine if the resident can participate in urinary toileting program. For many residents incontinence can be resolved or minimized by identifying potential reversible causes, including side effects from medication, urinary tract infection, immobility, environmental factors, etc. Nursing home staff must use clinical judgment as appropriate to reevaluate a resident's ability to participate in a toileting program. If the toileting program is unsuccessful, the facility should re-evaluate the needs of the resident and try a different toileting program. (RAI manual 3.0 page H-4)

There must be an underlying reason for a resident voiding in briefs rather than using an appropriate waste receptacle.

Q. How do you code Section G0400, lower functional limitation in range of motion?

A. Functional limitation in range of motion is limited ability to move a joint that interferes with daily functioning, such as ADLs or places resident at risk of injury. The intent of this item G0400 is to determine whether, the functional limitation in range of motion (ROM) interferes with the resident's activities of daily living or places resident at risk of injury. When completing this item, staff should refer back to item G0110 and view the limitation in ROM, taking into account activities that the resident is able to perform. Specific coding instructions for upper and lower extremities on how to conduct functional ROM limitations is on page G-36 of the RAI manual 3.0, October 2014.

Q. Are there penalties for doing extra quarterly MDS assessments?

A. There is no penalty for doing an early quarterly assessment. The federal requirements dictate that, at a minimum, three completed quarterly assessments must be in each 12-month period. OBRA assessments may be staggered to accommodate the facilities MDS due dates. However, with quarterly assessments the ARD must be within 92 days after the ARD of the previous OBRA assessment, (Quarterly, Admission, Significant Change of status Assessment (SCSA), Significant Correction of Prior Assessment (SCPA), or Annual Assessment + 92 days).

J0100: Pain Management

Q. Can we code pain medication on section J0100 even if the drug is not an analgesic (pain reliever medication)? For example, Neurontin is ordered twice daily for neuropathic pain.

A. The intent of item J0100 is to document a number of health conditions that affect the resident's functional status and quality of life. The items include an assessment of pain, which uses an interview with the resident or staff if the resident is unable to participate. The items assess the presence of pain, the frequency and intensity of pain, the effect on resident's function, and if pain is controlled or managed.

Neuropathic pain (according to WebMD) is a complex, chronic pain state usually accompanied by tissue injury. With neuropathic pain, the nerve fibers themselves may be damaged, dysfunctional, or injured. These damaged nerve fibers send incorrect signals to other pain centers. The impact of nerve fiber injury includes a change in nerve function both at the site of injury and areas around the injury. The cause of neuropathic pain remains unknown. However, some common causes of neuropathic pain include: alcoholism, amputation, back, leg, and hip problems, chemotherapy, diabetes, facial nerve problems, HIV infection or AIDS, multiple sclerosis, shingles, and spine surgery. Symptoms may include shooting and burning pain, tingling and numbness. Studies suggest the use of non-steroidal anti-inflammatory drugs, as treatment may ease the pain. Some require stronger pain medication, and in some cases anti-convulsing and anti-depressant drugs seem to work. Electrical stimulation and therapy are also used. Patients who are suffering from neuropathic pain may have a debilitating condition and may not be able to perform their activities of daily living (ADLs) effectively.

The facility may code pain medication regimen to manage the neuropathic pain. Code 1, yes on item J0100, if the medical record contains documentation that a scheduled pain medication was received to manage neuropathic pain.

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MDS records require signature, title, and accurate completion date.

V0200B1. Signature of the RN coordinating the CAA process.

V0200B2. Date that the RN coordinating the CAA process certifies that the CAAs have been completed.

Z0400. Signature of Persons Completing the Assessment or Entry/Death Reporting (certify accurate information)

Z0500A. Signature of the RN Assessment Coordinator Verifying Assessment Completion.

Z0500B. Date RN Assessment Coordinator signed assessment as complete.

Still not sure when to capture O0250 Influenza Vaccine?

Influenza or "flu" is a contagious respiratory illness caused by influenza viruses. It varies from mild to severe condition and at times leads to death. The Centers for Disease Control and Prevention (CDC) recommends a yearly flu vaccine, which is the best way to prevent influenza. To find flu vaccine near you, visit **http://flushot.healthmap.org/.** Check in advance about cost and insurance coverage; typically, health insurance covers influenza vaccine.

Receiving the flu vaccine as soon as it becomes available each year is best. Individuals can also take some basic steps to protect themselves and their families from getting flu and other respiratory infections by washing hands often, covering coughs and sneezes with tissue or sleeves and staying home when sick. (From CDPH Influenza information, last modified January 23,2015 at **http:www.cdph.ca.gov/HealthInfo/discond/Pages/Influenza(Flu).aspx**

Annual influenza epidemic in the United States typically peaks during winter season, which is around late December to early February. CDC recommends influenza vaccination to occur before the onset of influenza activity in the community. Health providers should offer vaccinations as soon as the vaccine becomes available (by October, if possible). Vaccination should be available and offered as long as the influenza viruses are circulating. To avoid missed opportunities for vaccination, providers should offer vaccination during routine healthcare visits and hospitalizations when the vaccine is available. {***Reference from the Advisory Committee on Immunization Practices (ACIP) from CDC website.***}

The Resident Assessment Instrument (RAI) user manual indicates the majority of influenza cases occur from October through May. However, residents should receive immunization as soon as the vaccine becomes available and continue until influenza is no longer circulating in their geographical area. The current seasonal influenza activity and the geographic interactive map is accessible on the CDC flu activity surveillance on the CDC web site.

(RAI 3.0 user manual, page O-8)

Nursing facilities must note when and where a resident received the flu vaccine or the reason why the resident did not receive the influenza vaccine for the current influenza vaccination season. Coding instructions for influenza vaccine are located on page O-7 of the RAI user manual 3.0, October 2014, as well as the steps for assessment from page O-5.

Best practice in coding the influenza vaccine on MDS is to use sound judgment and observe the influenza activity in your geographical area. Ask yourself "when did the **current influenza vaccination season** begin and when does it end**?"** The value of the current influenza vaccination is good until the new influenza season begins.

Helpful Links on Influenza Vaccine information:

http://www.cdph.ca.gov/healthinfo/discond/pages/influenza(flu).aspx

http://www.cdc.gov/flu/weekly/fluactivitysurv.htm

http://www.cdc.gov/flu/weekly/usmap.htm

http://www.cdph.ca.gov/healthinfo/discond/pages/influenza(flu).aspx

Please follow the link below for initial pneumococcal vaccine and a different second pneumococcal vaccine information:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9051.pdf

Expansion of Minimum Data Set (MDS) Focused Survey

On April 18, 2014, The Centers for Medicare and Medicaid Services released a Survey & Certification Letter (S&C) 14-22-NH, regarding the development of Focused Nursing Home Surveys. This survey focuses on evaluating coding practices of MDS and the relationship to care planning in nursing facilities.

On October 31, 2014, CMS released a second S&C Letter 15-06-NH indicating the nationwide expansion of the MDS Focused Survey. CMS began to conduct pilot surveys in nursing homes in five states. The pilot completed in August, 2014, enabled surveyors to review the nursing home resident assessment processes in more depth than the annual surveys.

From the examples given, findings from the surveys include inaccurate staging and documentation of pressure ulcers, lack of knowledge of antipsychotic drugs classification, and poor coding for the use of restraints. Deficiencies were cited in 24 out of 25 nursing homes.

Accurate daily staffing in nursing homes is critical. The staffing information assures "sufficient nursing staff" meets the resident's needs, (42 CFR 483.30(a) Sufficient Staff). Nursing facilities must comply with the requirements in 42 CFR Part 83, Subpart B to receive payment under Medicare or Medicaid, including the completion of the standard survey forms CMS-671. This form requires facilities to list the type of staff working in the facility and the number of hours worked. The plan is to conduct MDS Staffing Focused Surveys nationwide. The number of surveys will vary from state to state and expected to begin in early FY 2015.

On February 13, 2015, CMS released S&C:15-25-NH on MDS/Staffing Focused Surveys Update. CMS announced the expansion of MDS focused surveys nationwide in 2015. CMS revised the survey structure and processes (e.g., worksheets) to improve usage, scales, and effectiveness of the survey. How staffing levels fluctuates throughout the year is an additional focus in this review. The survey continues to assess compliance with 42 CFR 483.20 (Resident Assessment) and the applicable regulations that are identified during the investigatory process.

CMS received requests from nursing facilities for materials and methods on how to prepare for MDS 3.0 focused surveys. There are no new regulations involved in these surveys. The focus of this survey is on nursing home compliance with existing and long-standing regulations.

Deficiencies identified during surveys will result in relevant citations and enforcement actions in accordance with normal and existing CMS policy and regulations. In the event that additional care concerns (beyond the MDS and staffing of this focused survey) are identified during on-site reviews, those concerns will be investigated during the survey or, if immediate investigation is not possible, registered with the SA as a complaint for further review.

The effective date is immediate.

Another S&C Letter: 15-26 was released by CMS on February 13, 2015 on Nursing Home Compare "3.0" - Five Star Quality Rating System–Expanded and Strengthened. According to CMS the MDS focused surveys are also conducted in conjunction with CMS efforts to strengthen the Nursing Home Five-Star Quality Rating System.

HTML Links

MDS 3.0 Manual links:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/MDS30RAIManual.html

Quality Measures links:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIQualityMeasures.html

MDS 3.0 Training links:

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TrainingMaterials.html

The Medicare coverage requirements are implemented on February 2, 2015 and posted on the Medicare Learning Network (MLN) Matters document: MM9051.

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9051.pdf

http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-06.pdf

References:

RAI Manual 3.0 version, October 2014-R

Monthly All State CMS, RAI/SMA Teleconferences

CMS Nursing Home Initiative Website

CMS ODF (Open Door Forum LTC) Teleconference

CMS Survey & Certification Letter

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The content of this newsletter may be time-limited and the information may be superseded by the guidance published by CMS and CDPH at a later date. It is the provider's responsibility to keep the current updates from CMS and the State.